Physical Examination Form

Patient Name: _____ Date of Birth: ___/___/___ Sex: M / F

Height: _____ Weight: _____ Body Fat % (optional): _____ Pulse: _____

Blood Pressure: _____ Waist/Hip Ratio: _____ BMI: _____

Goals:_____

PHYSICAL EXAM Normal / Abnormal Findings Initials

____ Head
____ Eyes
____ Ears
____ Nose
____ Throat
____ Extremities
____ Thyroid
____ Nodes
____ Skin
____ Abdomen
____ Lungs
____ Heart
____ Breasts Male/Female
____ Prostate (conditional)
____ General Appearance
____ Reflexes

MEDICATIONS

ALLERGIES

MEDICAL HISTORY

SURGICAL HISTORY

Overall Examination: Normal Abnormal _____(reason)

I hereby certify that _____ has been examined by me on _____(date) and is found to be in good physical health.

Comments_____

_____

_____

_____

_____

_____

Practitioner's Signature_____

PHONE_____

ADDRESS_____

LifeQuest Sciences	Date:
	Driver's License:
	Patient Coordinator:

MEDICAL HISTORY QUESTIONNAIRE

Questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name		**Gender**	◻ Male ◻ Female
Address		**DOB**	
City		**Email**	
State		**Home Number**	
Zip Code		**Cell Number**	
Emergency Contact		**Phone**	
Height		**Weight**	lbs
Marital Status		**Occupation**	
Previous or Referring doctor		**Date of last physical exam**	

PERSONAL HEALTH HISTORY

Childhood illness: ◻ Measles ◻ Mumps ◻ Rubella ◻ Chickenpox ◻ Rheumatic Fever ◻ Polio

Immunization dates	Tetanus		Pneumonia	
	Hepatitis		Chickenpox	

	Influenza		MMR Measles, Mumps, Rubella	

List any medical problems that other doctors have diagnosed:
Surgeries? □ **Yes** □ **No**
If yes, explain:
Other hospitalizations? □ **Yes** □ **No**
If yes, explain:
Have you ever had a blood transfusion? □ **Yes** □ **No**

List all of your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of Drug	Strength	Frequency taken

Allergies to any medications?
□ **Yes** □ **No**
If "Yes", please explain:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Do you exercise?
□ **Yes** □ **No**

If "Yes", how many times per week and what form of exercise:

Diet	Are you dieting?			
	If "Yes", are you on a physician prescribed medical diet? Yes No			
	Number of meals you eat in an average day?			
	Rank salt intake	□ High	□ Medium	□ Low
	Rank fat intake	□ High	□ Medium	□ Low
Caffeine Servings per day?	□ Coffee	□ Tea	□ Cola	□ None
Alcohol	Do you drink alcohol? **Yes** □ **No**			□
	If yes, how often?			
Tobacco	Do you use tobacco? □ **No**			□ **Yes**
	If yes, how often?			
Drugs	Do you currently use recreational or street drugs? **Yes** □ **No**			□
	Have you ever given yourself street drugs with a needle? **Yes** □ **No**			□
Sex	Are you sexually active? **Yes** □ **No**			□

	If yes, are you trying for a pregnancy **Yes** □ **No**	□
	If not trying for a pregnancy list contraceptive or barrier method used: □ **No**	□ **Yes**
	Any discomfort during intercourse **Yes** □ **No**	□
	Are you HIV/AIDS positive? **Yes** □ **No**	□
Personal Safety	Do you live alone? **Yes** □ **No**	□
	Do you have frequent falls? **Yes** □ **No**	□
	Do you have vision or hearing loss? **Yes** □ **No**	□

FAMILY HEALTH HISTORY		
	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		

MENTAL HEALTH	
Do you feel depressed?	□ **Yes** □ **No**
Do you panic when stressed?	□ **Yes** □ **No**
Do you have problems with eating or your appetite?	□ **Yes** □ **No**
Do you cry frequently?	□ **Yes** □ **No**
Have you ever attempted suicide?	□ **Yes** □ **No**
Have you ever seriously thought about hurting yourself?	□ **Yes** □ **No**
Do you have trouble sleeping?	□ **Yes** □ **No**
WOMEN ONLY	
Age at onset of menstruation:	
Date of last menstruation:	
Period every _____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	□ **Yes** □ **No**

Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ **Yes**	☐ **No**
Have you had a D&C, hysterectomy, or Cesarean?	☐ **Yes**	☐ **No**
Any urinary tract, bladder, or kidney infections within the last year?	☐ **Yes**	☐ **No**
Any blood in your urine?	☐ **Yes**	☐ **No**
Any problems with control of urination?	☐ **Yes**	☐ **No**
Any hot flashes or sweating at night?	☐ **Yes**	☐ **No**
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ **Yes**	☐ **No**
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ **Yes**	☐ **No**
Date of last pap and rectal exam?		
MEN ONLY		
Do you usually get up to urinate during the night?	☐ **Yes**	☐ **No**
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ **Yes**	☐ **No**
Any blood in your urine?	☐ **Yes**	☐ **No**
Do you feel burning discharge from penis?	☐ **Yes**	☐ **No**
Has the force of your urination decreased?	☐ **Yes**	☐ **No**
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ **Yes**	☐ **No**
Do you have any problems emptying your bladder completely?	☐ **Yes**	☐ **No**
Any difficulty with erection or ejaculation?	☐ **Yes**	☐ **No**
Any testicle pain or swelling?	☐ **Yes**	☐ **No**
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

	Skin		Chest/Heart		Recent changes in:		Circulation
	Head/Neck		Back		Weight		Lungs

	E Ea Ears		Intestinal		EnerEnergy level		Bow Bowel
	Nose		Bladder		Ability to sleep		Other pain/discomfort

Treatment Questionnaire (Answer All That Apply)

Decreased concentration	□ **Yes** □ **No**	Decreased sociability	□ **Yes** □ **No**
Increased mood swings	□ **Yes** □ **No**	Decreased short term memory	□ **Yes** □ **No**
Increased stress levels	□ **Yes** □ **No**	Decreased long term memory	□ **Yes** □ **No**
Decreased personal drive	□ **Yes** □ **No**	Decreased sense of well being	□ **Yes** □ **No**
Depression	□ **Yes** □ **No**	Feeling less confident	□ **Yes** □ **No**
Difficulties sleeping	□ **Yes** □ **No**	Decreased sex drive	□ **Yes** □ **No**
Decreased energy	□ **Yes** □ **No**	Decreased endurance	□ **Yes** □ **No**
Decreased exercise	□ **Yes** □ **No**	Recovery from exercise is long	□ **Yes** □ **No**
Decreased muscle strength	□ **Yes** □ **No**	Decreased testicle size	□ **Yes** □ **No**
Decreased skin elasticity	□ **Yes** □ **No**	Decreased skin tone	□ **Yes** □ **No**
Decreased libido	□ **Yes** □ **No**	Increased fat deposits	□ **Yes** □ **No**
Increased wrinkle	□ **Yes** □ **No**	Increased muscle deterioration	□ **Yes** □ **No**
Increased fatigue	□ **Yes** □ **No**	Gynocomastia (male breast)	□ **Yes** □ **No**
Nipple sensitivity	□ **Yes** □ **No**	Hot flashes	□ **Yes** □ **No**
Heavy menstrual cycle	□ **Yes** □ **No**	Painful menstrual cycle	□ **Yes** □ **No**
Temperature intolerance	□ **Yes** □ **No**	Oral birth control or estrogen	□ **Yes** □ **No**
Thinning or loss of hair	□ **Yes** □ **No**	Thinning pubic hair	□ **Yes** □ **No**
Sagging or loose skin	□ **Yes** □ **No**	Thin / Dry skin	□ **Yes** □ **No**
Stiff joints in the morning	□ **Yes** □ **No**	Decreased bone mass	□ **Yes** □ **No**
Progressive osteoporosis	□ **Yes** □ **No**	Increased joint pain	□ **Yes** □ **No**
Increased back pain	□ **Yes** □ **No**	Gastrointestinal bleeding	□ **Yes** □ **No**
Muscle aches and pains	□ **Yes** □ **No**	Joint pain during exercise	□ **Yes** □ **No**
Endocrine disorder	□ **Yes** □ **No**	Hypertension	□ **Yes** □ **No**
Prostate cancer	□ **Yes** □ **No**	Other form of Cancer	□ **Yes** □ **No**
Poor wound healing	□ **Yes** □ **No**	Carpal Tunnel Syndrome	□ **Yes** □ **No**
Have you ever experienced problems with your joints? If "Yes" explain			
Have you experienced muscle aches and pains? If "Yes" explain			

Have you been on Hormone Therapy? If "Yes" explain	
Have you ever been on a testosterone program? If :Yes" explain	
Have you ever been on a HGH program? If "Yes" explain	

I, the patient, agree to fill out and submit this Health History accurately, truthfully, and completely. I also acknowledge that
failure to provide truthful, accurate and complete information on this Health History or to Progressive Health Institute LLC or physicians referred by Progressive Health Institute LLC could result my receiving inappropriate treatment. I also understand that the information submitted on this Health History will be held confidential and only disclosed or used in accordance with the Health Insurance Portability and Accountability and other applicable state and federal law.

Patient Signature: _____

Patient Printed Name: _____

Therapy Management Agreement

This agreement between _____ ("Patient") and *LifeQuest Sciences ("LQS")establishes guidelines and conditions for the use* of hormone replacement therapy ("H RT") involving DEA "controlled" or "scheduled" medications. LQS and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/practitioner relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and, therefore, these agents are prescribed with caution.

The patient agrees and accepts to the following conditions:

1. I understand that the medications I am receiving or will receive are prescribed for me based on diagnoses derived from my submitted medical history, and the results of lab work and a physical examination. The medications are to be used exclusively for treatment of hormonal deficiencies and related medical conditions in accordance with applicable state and Federal law.

2. I understand and agree that no medical treatment or medication provided to me by LifeQuest Sciences will be used for the purposes of bodybuilding, performance enhancement or physical appearance.

3. I certify that the answers I provided to the health questions on the Health History laboratories are accurate and correct to the best of my knowledge and that I have not been coached by any third party nor have I knowingly been deceptive for secondary gain, for medical treatment or prescription of a medication.

4. I will not attempt to obtain HRT medications from any other health care practitioner without disclosing my current medical usage of HRT or other medications. I understand that it may be against the law to do so.

5. I have discussed and understand the risks and benefits associated with HRT. I will immediately report any adverse side effect related to the use of my HRT to LifeQuest Sciences and discontinue use until advised to resume usage by LifeQuest Sciences. I voluntarily assume any and all possible risks which may be associated with HRT.

6. I understand that representatives of LifeQuest Sciences and/or Licensed Physicians Assistant are available for questions and/or concerning during normal business hours throughout the course of my treatment.

7. I agree that the HRT medications furnished by LifeQuest Sciences are for my personal use only and for no other purpose. I will not share, sell, or trade my

medications. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.

8. I will be able to purchase the medications from the pharmacy designated by LifeQuest Sciences and the pharmacy will send medication directly to me. I understand I have the right to purchase my medications from any pharmacy of my choice. If I chose to obtain medications from a pharmacy of my own choice, I must notify LifeQuest Sciences in writing of my intention to do so and include the name of the pharmacy in my request.

9. I agree and understand that federal regulations prohibit the return of prescribed medications.

10. I understand that HRT treatment and medications are not covered by health insurance. I agree that all services and medications provided by LifeQuest Sciences or its associated providers are to be paid for in advance. I will not seek reimbursement through my health insurance company, Medicare, Medicaid, or other third party payer.

11. I agree that the LifeQuest Sciences patient/physician relationship is not intended to replace the existing patient/physician relationship with my current primary care provider (PCP) and the treatment provided by LifeQuest Sciences will be in conjunction with the care provided by my current PCP.

12. I agree that I will use my medication at the prescribed rate and dosage and will keep the medication in its respective labeled container.

13. I understand that LifeQuest Sciences only treats patients over the age of 30 with documented symptoms of hormone deficiencies (Hypogonadism and Adult Growth Hormone Deficiency). No prescription will be provided unless a clinical need exists based on required lab work, physician consultation, and current health history through either patient's personal physician or a LifeQuest Sciences - affiliated physician. Agreeing to lab work does not automatically qualify patient to clinically necessity and prescription of HRT.

14. I understand that LifeQuest Sciences does <u>not</u> carry Malpractice Insurance. I have read and agree to the terms of this the Therapy Management Agreement.

Patient Signature:

Printed Name: _____

Date: _____

LifeQuest Sciences

NOTICE OF PRIVACY PRACTICES

Effective November 01, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you pursuant to the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use or disclose your protected health information and with whom we may share that information. "Protected health information" is individually identifiable health information. Such information may include, for example, your age, address, or e-mail address, and it relates to your past, present, and future physical or mental health or condition and related health care services. It is information that you have given to us or that we have learned about you when you were a patient. This Notice also describes your rights and our legal duties related to this information.

I. Acknowledgement of Receipt of this Notice. You will be asked to provide a signed acknowledgement of your receipt of this Notice to ensure that you are aware of the possible uses and disclosures of your protected health information and privacy rights. Delivery of your health care services is not conditioned upon your signature. If you decline to provide a signed acknowledgement, we will continue to provide treatment to you and will use and disclose your protected health information for treatment, payment, and health care operations as necessary.

II. Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations.

A. *Treatment, Payment, and Health Care Operations*. The following describes different ways we use and disclose your protected health information for treatment, payment, and health operations, including examples of each.

i. Treatment. We may use or disclose your health information to provide you with medical and behavioral health services, including substance abuse prevention, treatment, and intervention. You must sign a written consent before we can share your information for treatment purposes. If you consent, we may disclose your information to people providing, managing, and coordinating your care. This includes the coordination or management of your care with a third party. For example, we may disclose your protected health information to a counselor or case manager so he or she can make decisions related to your care. We may also disclose information to a pharmacist about other drugs you have been prescribed to avoid potential adverse interactions.

ii. Payment. We may use or disclose your health information so that we can bill and collect payment from you, an insurance company, or someone else for the health care services you receive from us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether the plan will pay for the treatment. For example, we may need to give your health plan information about a planned drug screening so your health plan will pay us or reimburse us for the screening.

iii. Health Care Operations. We may use or disclose your health information, if you sign a written consent, to run necessary administrative, business management, quality assurance, internal audit, and educational functions. For example, we may use or disclose your health information to conduct competence and qualification evaluations of our staff that care for you. We may use health information to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective.

iv. Fundraising Activities. As part of our health care operations, we may use and disclose a limited amount of your health information to contact you for fundraising efforts. The health information released for these fundraising purposes can include your name, address, other contact information, gender, age, date of birth, dates on which you received service, health insurance status, the outcome of your treatment with us and your treating physician's name. Any fundraising communications you receive from us will include information on how you can elect not to receive any further fundraising communications. You can tell us not to contact you again.

B. *Other Uses and Disclosures of Health Information Without Authorization.* In addition to uses and disclosures of your health information for treatment, payment, and health care operations, we may also use or disclose health information without authorization in the following circumstances:

i. To you, the patient;

ii. If ordered by a court;

iii. For health oversight activities such as, for example, internal and external investigations, inspections, or licensure actions.

III. Uses and Disclosures of Protected Health Information Only With Authorization.

A. Except for the purposes defined and listed above, we will not use or disclose your health information for any purpose unless you give us your written authorization. Circumstances that may require written authorization include use or disclosure of psychotherapy notes, for marketing purposes, and for the sale of your h ealth information.

B. *Revocation of Authorization.* If you give us an authorization, you can withdraw or amend this written authorization at any time. To withdraw your authorization, deliver a written revocation to 5155 Corporate Way, Suite B, Jupiter, FL 33458 US ____ If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

IV. Your Rights Regarding Your Protected Health Information.

A. You have certain rights regarding your health information, which are listed below. If you want to exercise any of your rights, you must do so in writing by completing a form that you can obtain from our Privacy Officer. In some cases, we may charge you for the costs of providing materials to you. You can get more information about how to exercise your rights and about any costs that we may charge for materials by contacting our Privacy Officer at 855-731-9156.

i. *Right to Inspect and Copy.* With some exceptions, you have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in an electronic health record, if any, you may request that we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information for you electronically (unless we deny your request for other reasons). We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.

ii. *Right to Amend.* You have the right to amend your health information maintained by or for us, or used by us to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.

iii. *Right to an Accounting of Disclosures.* You have the right to request a list and description of certain disclosures by us of your health information.

iv. *Right to Request Restrictions.* You have the right to request a restriction or limitation on the protected health information we use or disclose about you (a) for treatment, payment, or health care operations, (b) to someone who is involved in your care or the payment for it, such as a family member or friend, or (c) to a health plan for payment or health care operations purposes when the item or service has been paid for out of pocket in full by you or someone on your behalf (other than the health plan). For example, you could ask that we not use or disclose information about a laboratory test ordered or a medical device prescribed for your care. Except for the request noted in (c) above, we are not required to agree to your request. Any time we agree to such a restriction, it must be in writing and signed by our Privacy Officer or his or her designee.

v. *Right to Request Confidential Communications.* You have the right to request that we communicate with you about health matters in a certain way or at a certain place. We will accommodate reasonable requests. For example, you can ask that we only contact you at work or by mail.

vi. *Right to a Paper Copy of This Notice.* You have the right to a paper copy of this Notice, whether or not you may have previously agreed to receive the Notice electronically.

vii. *Right to be Notified of a Breach.* You have the right to be notified if there is a breach (a compromise to the security or privacy of your health information) due to your health information being unsecured. We are required to notify you within 60 days of discovery of a breach.

V. Revisions to this Notice. We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which the material change is reflected. We will post the revised Notice at clinical locations and on our website and provide you a copy of the revised notice upon your request.

VI. Questions or Comments. If you have any questions about this Notice, please contact our Privacy Officer at 855-731-9156. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at 855-731-9156. You will not be penalized for filing a complaint. This Notice tells you how we may use and share health information about you. If you would like a copy of this Notice, please ask your health care provider.

VII. Authorization for Release for the Use of Cell Phone, E-mail and Voicemail Communications. Unless otherwise specified in writing, you hereby consent for LQS to communicate with you via (*initial all which apply*):

[_____] telephone;
[_____] voicemail;
[_____] e-mail; and
[_____] text message;

For the purpose of conveying Protected Health Information or other information about the care or serviced provided by LifeQuest. You understand that telephone, voicemail, e-mail and text message communications are not secure forms of communication and that confidentiality of any such communication cannot be ensured. This authorization may be revoked at any time by providing written notice of such revocation to LQS.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices from LifeQuest Sciences. I am aware of the possible uses and disclosures of my protected health information and privacy rights.

Signature: _____

Name: _____

Date: _____

Dr. Juan Vidal, MD
Gary Olenick, CRNA,APRN
5155 Corporate Way, Suite B, Jupiter, FL 33458
855-731-9156

BY SIGNING THIS FORM, I HERBY AUTHORIZE THE RELEASE OF ANY PERTINENT MEDICAL RECORDS, RADIOLOGIC STUDIES AND LAB WORK TO LifeQuest Sciences FOR:

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

PATIENT ADDRESS:_____

PATIENT PHONE:_____

PATIENT SIGNATURE_____

DATE:_____

5155 Corporate Way Suite B, Jupiter, FL 33458

855-731-9156

Authorization for Credit Card Use

Please PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____Visa _____Mastercard ____Discover _____Amex

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

I authorize LifeQuest Sciences to charge the agreed upon proposal amount presented to me to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.
This agreement will remain active for charges placed with this office until card holder discontinues this service.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____